TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Fondren Orthopedics

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-17-2474-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 14, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have added a 59 modifier to code 29876 as Tricompartmental synovectomy was performed. We have enclosed the coded operative report and the claim for your review."

Amount in Dispute: $488.37

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Insurance Co of the State of Pennsylvania is Flahive Ogden & Latson. Flahive Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on April 25, 2017.

28 Texas Administrative Code §133.307(d)(1) states:

> Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
>
> (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute**. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received from Flahive, Ogden & Latson to date. The Division concludes that the carrier failed to respond within the timeframe required by §133.307(d)(1). For that reason the Division will base its decision on the information available.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 9, 2016	29876	$488.37	$488.37

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?

Findings

1. The requestor is seeking $488.37 for Code 29876 – "Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments" rendered on December 9, 2016. The only explanation of benefits submitted with the request for medical fee dispute resolution shows the insurance carrier denied disputed services with claim adjustment reason code W3 – "Additional payment made on appeal/reconsideration." No additional payment was made and the requestor has requested MFDR. Therefore the service in dispute will be reviewed per applicable rules and fee guidelines.

2. This professional service is subject to 28 Texas Administrative Code §134.203 (b) (1) and (c) (1) which states in pertinent parts,

   (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

   (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

   (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (annual conversion factor). For Surgery when performed in a facility setting, the established conversion factor to be applied is (annual conversion factor)."

   The submitted medical bill shows two surgical procedures performed on the date of service in dispute. The Code 29888 was paid at billed amount and is not in dispute. Review of the Medicare payment policy found in the Medicare Claims Processing Manual at www.cms.gov, for code 29876 finds the "Multiple procedure reduction guidelines" shown below apply.

   Medicare pays for multiple surgeries by ranking from the highest MPFS amount to the lowest MPFS amount. When the same physician performs more than one surgical service at the same session, the allowed amount is 100% for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical codes is based on 50% of the MPFS amount.

   Therefore the maximum reasonable reimbursement shown above in Rule 134.203 (c) (1) will be reduced by 50% as this is the lower ranked procedure. This calculation is as follows:

Date of Service	Billed Amount	Allowable	DWC Conversion Factor / Medicare Conversion Factor) x Allowable
December 9, 2016	$2,960.00	$683.37	71.32/35.8043 x $683.37 = $1,361.23 ÷ 50% = $680.62
December 9, 2016	$5,735.00	$1,025.17	71.32/35.8043 x $1,025.17 = $2,042.08

The maximum allowable reimbursement is $2,722.70. The carrier previously paid $2,042.08. The requestor is seeking $488.37. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $488.37.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $488.37, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 9, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.